TRICARE SENIOR PRIME
ENROLLMENT APPLICATION

Form Approved
OMB No. 0720-0018
Expires Aug 31, 2002

FOR OFFICIAL USE ONLY:
PROPOSED EFFECTIVE DATE OF COVERAGE

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.
RETURN YOUR COMPLETED APPLICATION IN THE ADDRESSED ENVELOPE PROVIDED.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 301; 10 USC Chapter 55, 42 USC Chapter 7, Subchapter XVIII; EO 9397.
PRINCIPAL PURPOSE: To be considered for enrollment in the TRICARE Senior Prime program sponsored by the Department of Defense.
ROUTINE USES: Information from application forms and related documents may be given to the Department of Health and Human Services consistent with their statutory administrative responsibilities under the Medicare Program. Appropriate disclosure may be made to other Federal, state, local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Senior Prime program.
DISCLOSURE: Voluntary; however, failure to provide information will result in your enrollment application not being processed.

All blocks must be completed. Retain a copy of each page for your records.

SECTION I - PERSONAL INFORMATION

1. LAST NAME	2. FIRST NAME	3. MIDDLE INITIAL
	S A M P L E	

4. DATE OF BIRTH *(Month, day, year)*	5. SEX *(X one)*	6. SOCIAL SECURITY NUMBER
	☐ MALE ☐ FEMALE	

7. SPONSOR'S SOCIAL SECURITY NUMBER	8. DEERS DEPENDENT SUFFIX *(If known)*

9. PERMANENT RESIDENCE ADDRESS

a. NUMBER AND STREET *(Include apartment number)*

b. CITY	c. COUNTY	d. STATE	e. ZIP CODE

10.a. TELEPHONE NUMBER *(Include area code)*	11. MAILING ADDRESS *(If different from above)*
b. WHEN IS THE BEST TIME TO CALL?	

SECTION II - ELIGIBILITY INFORMATION	(X) YES	NO
12. Have you been diagnosed with endstage renal disease (kidney disease)?		
13. Are you currently enrolled in Medicare Part A and Part B?		

14. Refer to your Medicare Card for the following information:		
a. MEDICARE CLAIM NUMBER	b. HOSPITAL PART A EFFECTIVE DATE	c. MEDICAL PART B EFFECTIVE DATE

SECTION III - ADDITIONAL INFORMATION *(Your answers to these questions will not affect your ability to enroll.)*	(X) YES	NO
15a. Are you currently receiving Medicaid Health Care Benefits?		

b. IF YES, ID NUMBER	c. EFFECTIVE DATE

16a. Do you currently reside in a nursing facility, care home, or institution?	YES	NO

b. IF YES, DATE ADMITTED	b. NAME OF FACILITY	c . TELEPHONE NUMBER *(Include area code)*

17a. Do you have health insurance other than Medicare?	YES	NO

(1) IF YES, INSURANCE COMPANY NAME			
(2) INSURANCE COMPANY ADDRESS *(If known)*: STREET **SAMPLE**	(3) CITY	(4) STATE	(5) ZIP CODE
(6) POLICYHOLDER NAME	(7) POLICY NUMBER	(8) EFFECTIVE DATE	

17b. Is this insurance a Medicare Supplement, such as Medigap?	YES	NO
c. Do you intend to terminate that insurance? If yes, termination date: _____		

d. Is this other health insurance through your employer or your spouse's current employer?

☐ YES, THROUGH MY EMPLOYER	☐ YES, THROUGH MY SPOUSE'S EMPLOYER	☐ NO

(1) IF YES, EMPLOYER NAME			
(2) EMPLOYER ADDRESS *(If known)*: STREET	(3) CITY	(4) STATE	(5) ZIP CODE

(6) POLICYHOLDER NAME	(7) ID NUMBER	(8) GROUP NO.	(9) GROUP PLAN

SECTION IV - CONDITIONS OF ENROLLMENT *(Initial each block.)*	
	18. BENEFICIARY ORIENTATION. I understand there are TRICARE Senior Prime orientation sessions available to learn more about the plan.
	19. PROJECT DURATION. I understand that TRICARE Senior Prime is currently scheduled to end on December 31, 2001.
	20. ENROLLMENT. I understand that I must be enrolled in Medicare Part A and Part B to participate in TRICARE Senior Prime (TSP). I understand that TSP will send me final confirmation of my enrollment in TSP. I understand that I should not disenroll from any Medicare supplemental plan or Medigap/Medicare select plan until I receive that confirmation from TRICARE Senior Prime.
	21. APPLICATION DENIED. I understand that if my application is denied, I will be provided a written explanation for the denial.
	22. DISENROLLMENT FROM OTHER MEDICARE + CHOICE ORGANIZATION PRODUCTS. I understand that enrollment in TRICARE Senior Prime will result in disenrollment from any other Medicare + Choice Organization's product in which I am currently enrolled.
	23. SUPPLEMENTAL INSURANCE: I understand that if I cancel or drop any supplemental insurance (Medigap) and later decide to disenroll from TRICARE Senior Prime, or the Demonstration ends, I may not be able to obtain new supplemental insurance at the same terms and conditions.
	24. ROUTINE CARE. As a member of TRICARE Senior Prime, routine care will be provided or arranged through my Primary Care Manager (PCM) at the Military Treatment Facility (MTF). All of my health care (other than emergencies or urgently needed services) must be provided or authorized by my PCM.
	25. SPECIALTY CARE. When I need specialty services that are not available in the MTF, my PCM will refer me to a civilian provider who is participating in the TRICARE network. If a network provider is not available, I may be referred to a non-network provider. Network providers will furnish information about my care to my PCM. If I use civilian providers without authorization from my PCM, except in an emergency or for urgent care, payment will be denied. I have the right to appeal service and payment denials.
	26. ABILITY TO VOLUNTARILY DISENROLL. I understand that I may disenroll from TRICARE Senior Prime by submitting a written request to the MTF, the TRICARE Service Center, or to my local Social Security office. If my disenrollment request is received on or before the 10th day of the month, my disenrollment will be effective on the first day of the month following the month in which my disenrollment request is received at the MTF, TRICARE Service Center, or Social Security office. If my disenrollment request is received after the 10th day of the month, my disenrollment will be effective the first day of the second calendar month after my disenrollment is received.

SECTION IV - CONDITIONS OF ENROLLMENT *(Continued)*	
	27. INVOLUNTARY DISENROLLMENT. I understand that I may be involuntarily disenrolled from TRICARE Senior Prime (TSP) if I move out of the TSP geographic area; if I knowingly provide fraudulent information on the application form; if I intentionally permit others to use my enrollment card to receive services from TSP, or if my behavior is disruptive, unruly, abusive or uncooperative to the extent that my continuing enrollment in TSP seriously impairs TSP's ability to furnish services to myself or other enrollees.
	28. INFORMATION EXCHANGE. By enrolling in TRICARE Senior Prime, I authorize civilian and MTF providers to release medical and other relevant information about me as required to administer TRICARE Senior Prime. I authorize the Department of Health and Human Services to release necessary information to DoD regarding my eligibility to enroll in TSP.
	29. LEAVING SERVICE AREA. I understand that I must inform the MTF's TRICARE Service Center prior to permanently moving out of the service area. Also, I must inform the Service Center prior to temporarily leaving the service area for more than 6 months. My absence from the service area for such a period of time means DoD will take action to disenroll me from TRICARE Senior Prime and return me to traditional Medicare for medical coverage. DoD will send me written notification of action taken, to include the effective date of my disenrollment from TRICARE Senior Prime.
	30. FINANCIAL RESPONSIBILITY. When I am referred by my PCM to a TRICARE network or non-network provider for care not available in the MTF, the MTF is responsible for the cost of my care, except for my co-payments as explained in the TRICARE Senior Prime Beneficiary Brochure. I understand that I must also continue to pay my Medicare Part B premiums and Part A, if applicable.
	31. OUT OF SERVICE AREA - FINANCIAL RESPONSIBILITY. I understand that, when I am out of the service area, I will be responsible for payment in full for all care I receive, except for urgent care, emergency care, or renal dialysis.
	32. MEDICARE "LOCK-IN". I understand that as long as I am enrolled in TRICARE Senior Prime, I may not use my fee-for-service Medicare benefit. If I seek care outside of the MTF without prior authorization from my MTF Primary Care Manager, except for emergency care, urgent care, or renal dialysis, when I am out of the area, I understand that I will be fully responsible for payment for that care.
	33. ACCESS STANDARDS. I understand that normally, enrollees in a Medicare + Choice Organization should be able to get to their Primary Care Manager's office within 30 minutes.
	34. ACCESS WAIVER. I want to enroll in TRICARE Senior Prime program and waive the access standard if I live too far away to reach the MTF in 30 minutes.

SECTION IV - CONDITIONS OF ENROLLMENT *(Continued)*

35. MULTIPLE PRIMARY CARE SITES.
If you live within an area with two participating Military Hospitals you may elect to be enrolled at either facility. If locally available, you may prioritize your choices of Military Hospital and Primary Care Manager.

a. PLEASE INDICATE YOUR FIRST CHOICE OF MILITARY HOSPITAL

b. FIRST CHOICE OF PCM AT THIS MILITARY HOSPITAL	c. SECOND CHOICE OF PCM AT THIS MILITARY HOSPITAL

d. PLEASE INDICATE YOUR SECOND CHOICE OF MILITARY HOSPITAL

e. FIRST CHOICE OF PCM AT THIS MILITARY HOSPITAL	f. SECOND CHOICE OF PCM AT THIS MILITARY HOSPITAL

SECTION IV - AUTHORIZATIONS

36. BENEFICIARY.
I affirm that all information I have provided on this form is true and correct.
I agree to comply with all rules and requirements of TRICARE Senior Prime.
I understand and agree that any failure on my part to provide correct information and to comply with all TRICARE Senior Prime rules and requirements may result in my disenrollment.

a. PRINTED NAME *(Last, First, Middle Initial)*	b. SOCIAL SECURITY NUMBER

c. SIGNATURE **S A M P L E**	d. DATE

37. IF BENEFICIARY IS UNABLE TO SIGN:
If the beneficiary is unable to sign, a court-appointed Legal Guardian or person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign the following line. A copy of the Proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law must be attached.

a. PRINTED NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE

38. IF ANYONE HELPED THE BENEFICIARY FILL OUT THIS FORM:
They must sign the following line.

a. PRINTED NAME *(Last, First, Middle Initial)*	b. RELATIONSHIP TO BENEFICIARY

c. SIGNATURE	d. DATE